

Bureau of Health Care Quality & Compliance

PRINTED: 09/23/2009
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2128HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/27/2009
NAME OF PROVIDER OR SUPPLIER DESERT WILLOW TREATMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6171 W CHARLESTON BLVD, Bldg. #17 LAS VEGAS, NV -89402 89146		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 000	Initial Comments This Statement of Deficiencies was generated as a result of a State licensure focused survey and complaint investigation conducted in your facility on 08/24/09 and finalized on 08/27/09, in accordance with Nevada Administrative Code, Chapter 449, Hospitals. Complaint #NV00022688 was substantiated with deficiencies cited. (See Tags S0320, S0325, S0328, S0329) Complaint #NV00022683 was substantiated with deficiencies cited. (See Tag S0320) A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included. Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The following deficiencies were identified	S 000	S 060 – Quality Improvement Desert Willow Treatment Center (DWTC) will ensure that the hospital has an effective, comprehensive quality improvement program to evaluate the provision of care to its patients. 1. DWTC, through its Quality Assurance Department, will indicate, track, trend, introduce preventive strategies, and provide innovated alternatives to improve the process of using chemical restraints. The Quality Assurance Specialist will enhance the tracking method of chemical restraints by identifying specific trends and factors precipitating and resulting from chemical restraints. In doing so, the Quality Assurance Specialist will continue to consult with the Medical Director and Director of Nursing (DON) to operationally define trends and factors related to chemical restraints. The identification of specific trends and factors related to chemical restraints will assist DWTC in developing preventive strategies and alternatives for improving the process of using chemical restraints. The Quality Assurance Specialist will report identified trends and factors resulting from chemical restraints to the monthly Leadership Executive Team (LET) meeting. LET will utilize data to determine preventive strategies and alternatives for improving the process of using chemical restraints. The policy and procedures pertaining to chemical restraints were revised to improve the process of using chemical restraints. A series of mandatory staff in-services were conducted at DWTC to include retraining and improving the current process of using chemical restraints.	11/20/09 11/20/09 12/31/09 01/29/10 10/15/09 10/29/09	
S 060 SS=F	NAC 449.3152 Quality Improvement 1. The governing body of a hospital shall ensure that the hospital has an effective, comprehensive	S 060			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Linda K. Santhiago, Ph.D., LSW, CPMI
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Hospital Administrator
HOSPITAL ADMINISTRATOR

10/29/09
10/29/09

STATE FORM

6899

HPKN11

If continuation sheet 1 of 35

Clinical Program Manager II
CLINICAL PROGRAM MANAGER II

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2128HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/27/2009
NAME OF PROVIDER OR SUPPLIER DESERT WILLOW TREATMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6171 W CHARLESTON BLVD, <i>BLDG #17</i> LAS VEGAS, NV 89402 <i>89146</i>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 060	Continued From page 1 quality improvement program to evaluate the provision of care to its patients. This Regulation is not met as evidenced by: Based on interview, document review and chart review the facility failed to ensure there was an effective, comprehensive quality improvement program to evaluate the provisions of care for its patients as follows: 1. The facility did not indicate, track, trend, introduce preventive strategies or provide innovated alternatives to improve the process of using of chemical restraints. 2. Patient injuries during Conflict Prevention and Response Training (CPART) Holds/Seclusion were not tracked nor trended. 3. The facility was not able to provide readily retrievable records of all denials of patient's rights in accordance with the facility's Patient's Rights Policy #2.01 originally effective 1/1/2005 with a revision date of 12/07 Section III, M. 4. The facility did not have a an effective way to evaluate their incident investigation process to ensure the safety and protection of their patients. 6. The facility had no documented evidence of a plan to reduce the number of chemical and physical restraints. Severity: 2 Scope: 3	S 060	2. The Quality Assurance Specialist has begun to improve and build upon the process of tracking patient injuries during Conflict Prevention and Response Training (CPART) holds and seclusions. The method is improving from tracking whether or not an injury had occurred to tracking specific types of injuries (i.e., leg, arm, shoulder, rug burn, etc.). The Quality Assurance Specialist will report the specific types of injuries to the monthly LET meeting. LET will utilize data to determine preventive strategies and to assist in developing a plan for reducing the number of restraints. 3. DWTC will provide readily retrievable records of all denials of patient's rights per policy. The Quality Assurance Specialist will track denial of rights and all denial of rights forms will be filed along with its specific incident. Note: During the September 17, 2009 meeting of the Commission on Mental Health and Developmental Services, this body committed to discuss the Seclusion and Restraint Emergency Procedures form in relation to patient denial of rights at their next meeting scheduled for November 19, 2009. If the intent of the Commission is to continue to utilize the form as a denial of rights, then a request will be made to include "Denial of Rights" in the title of the form. The Commission's authority regarding denial of rights is set forth in NRS 433.534. DWTC will follow the guidance of the Commission and the Attorney General's Office regarding the reporting requirements and the Commission's decisions per their statutory authority. 4. DWTC is developing a more effective and efficient way to evaluate its incident investigation process to ensure the safety and protection of all patients.	11/13/09 12/04/09 11/13/09 11/19/09 11/30/09
S 216 SS=D	NAC 449.340 Pharmaceutical Services 2. The pharmacy and area for drug storage must be administered in accordance with all applicable state and federal laws. This Regulation is not met as evidenced by:	S 216	The Quality Assurance Specialist has been prioritizing and expediting all incident investigations. Identified staff involved in an investigation are quickly moved to another unit.	09/08/09

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2128HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/27/2009
NAME OF PROVIDER OR SUPPLIER DESERT WILLOW TREATMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6171 W CHARLESTON BLVD, Bldg. #17 LAS VEGAS, NV 89102 89146		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 216	Continued From page 2 Based on observation, interview and policy and procedure review the facility failed to ensure psychotropic medication was kept secured in a locked storage area in accordance with applicable state and federal laws. Severity: 2 Scope: 1	S 216	placed on administrative duties, or placed on administrative leave, depending on severity of incident. All identified witnesses (including patients) are interviewed, and all proper authorities are informed of incident per policy time frames. Report summarizing investigation is completed in an expedited fashion and disseminated to all proper authorities.	11/30/09
S 297 SS=F	NAC 449.361 Nursing Service 8. The chief administrative nurse shall define the policies, procedures and standards relating to the provision of nursing services and shall ensure that the members of the nursing staff carry out those policies, procedures and standards. The policies, procedures and standards must be documented and accessible to each member of the nursing staff in written or electronic form. The chief administrative nurse must approve each element of the policies, procedures and standards before the element may be used or put into effect. This Regulation is not met as evidenced by: Based on interview, record review and document review the chief administrative nurse failed to ensure members of the nursing staff consistently followed the facilities restraint and suicide prevention policies and procedures for 9 of 11 patients. (Patients #1, #2, #3, #4, #5, #6, #7, #8, and #9) 1. Nursing staff failed to consistently obtain physicians' orders for all instances of physical and chemical restraint use. 2. Nursing staff failed to document all instances of physical and chemical restraint use on the facility's "Restraint Incident Report" form.	S 297	DWTC will continue to refine its incident investigation process and revise policies to reflect an effective means to ensure the safety and protection of all patients. 6. DWTC is developing a plan to reduce the number of chemical and physical restraints. CPART courses for certification and recertification were reviewed and revised to ensure the protection of all patients. CPART courses include increased practice and role modeling (return demonstration) of all approved CPART holds. Courses also include increased emphasis on preventive techniques and de-escalation content (proactive intervention). Policies, including the Incident/Accident Reporting policy and Restraint/Seclusion of Patients policy, were revised for heightened clarity and for the protection of all patients. A series of mandatory staff in-services were conducted at DWTC to include retraining on policies, emphasis on preventive and de-escalation techniques, and use of chemical and physical restraints. The Quality Assurance Specialist will be tracking and reporting specific trends and factors pertaining to chemical and physical restraints, including involved patients and staff, type of injuries, type of holds, etc. This data will be utilized to determine preventive strategies, alternatives, and a plan to reduce the number of chemical and physical restraints.	01/29/10 09/30/09 10/29/09 10/15/09 10/29/09 01/29/10

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2128HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/27/2009
NAME OF PROVIDER OR SUPPLIER DESERT WILLOW TREATMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6171 W CHARLESTON BLVD, Bldg. #17 LAS VEGAS, NV 89102 89146		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 320	<p>Continued From page 6</p> <p>Patient #1 reported on 6/15/09, that he was physically abused by Employees #7 and #8 who twisted the patient's arm behind his back and pushed the patient up against a wall in the facility gym. The patient complained of pain in his arm as a result of the action by the two employees of the facility.</p> <p>Residential Treatment Center Services Continued Stay Request Note dated 6/18/09 indicated the patient was restrained on 6/15/09 for physical aggression towards a peer. The assessment was completed by Employee #6.</p> <p>On 8/25/09 at 10:20 AM, an interview was conducted with Employee #6 who reported Patient #1 complained on 6/15/09, that he was grabbed by Employee #7 and Employee #8 who twisted his arm behind his back and pushed him up against a wall in the facility gym. Employee #6 reported the patient was very upset when he spoke about the incident and complained that his arm hurt. He asked both employees to stop restraining him, but it felt like a long time passed before both employees released the restraint hold. Employee #6 reported the patient complained of pain in his shoulder and an x-ray was completed to rule out an injury. Employee #6 reported that she believed the incident occurred and assisted the patient in filling out a complaint about the incident which was submitted to Employee #2.</p> <p>An incident report by Quality Assurance dated 7/30/09 indicated Patient #1 made an allegation of physical abuse from two staff members that was reported to Child Protective Services (CPS). An internal investigation was being conducted by Employee #2.</p>	S 320	<p>Create and institute signed Statement of Understanding of having read, understood, and will adhere to all policies and procedures pertaining to restraints and suicide precautions.</p> <p>Develop database to track signed statements.</p> <p>Rounding Sheet completed by nurse supervisors has been implemented. This includes the monitoring on each unit (at least 2x per shift @ random times) of documented physician orders and reasons and results for all IM PRN medication. If any errors are found, there will be immediate follow-up of corrective procedures. Rounding Sheet is reviewed daily by DON and CPM II for oversight and compliance.</p> <p>Nurse supervisors receive from unit charge nurses completed Incident/Accident Report, Seclusion and Restraint Emergency Procedures Denial of Rights form, Pain Assessment form, and the Restraint and Seclusion Debriefing & Positive Behavior Intervention Plan for each restraint by the end of shift incident occurred. Forms are reviewed for accuracy and completeness, including the documentation that parents or legal guardians were contacted when suicide precautions were initiated. If any error is detected, there will be immediate follow-up of corrective action. Forms are submitted daily to DON for review and oversight.</p> <p>The Quality Assurance Specialist will compare patient progress notes with database that contains all submitted Incident/Accident Reports and Restraints/Seclusions for accurately capturing and appropriately documenting all incidents. Twenty patient cases will be randomly selected per quarter. Discrepancies will be brought to the attention of the CPM II within one business day for further investigation and corrective action if necessary.</p> <p>S 298 – Nursing Service</p> <p>DWTC will ensure nursing staff has the knowledge to operate an aerosol machine, as well as any other equipment/machine used by nursing staff.</p>	<p>10/29/09</p> <p>10/15/09</p> <p>10/08/09</p> <p>09/21/09</p> <p>09/16/09</p>

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2128HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/27/2009
NAME OF PROVIDER OR SUPPLIER DESERT WILLOW TREATMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6171 W CHARLESTON BLVD, Bldg. #17 LAS VEGAS, NV 89102 89146		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 320	Continued From page 7 On 8/25/09 at 1:20 PM, an interview was conducted with Employee #2. Employee #2 reported she spoke with Employee #8 after receiving a complaint about Patient #1 being physically restrained by Employee #7 and Employee #8. Employee #2 reported she told Employee #8 she was processing a complaint about the incident where Patient #1 was held against the wall with his arm behind his back in the facility gym. Employee #8 confirmed the incident had occurred in the gym and told Employee #2 the patient was trying to run out of the gym and she had to stop him from leaving the gym. Employee #2 reported, after requesting and receiving a written statement about the incident from Employee #8, she was shocked that Employee #8's written statement was different from the verbal statement given to her earlier. Employee #2 reported Employee #8's written statement made no mention of physically restraining the patient with his arm behind his back. The statement indicated the patient was redirected and accompanied to a matted area where he was given teaching interaction and verbal reassurance until he was calm. Employee #2 reported she conducted an investigation of the incident and obtained statements from Employee #6, Employee #7, Employee #8, and Employee #9 and felt the incident involving a physical restraint did occur. Employee #2 acknowledged the facilities abuse policy and procedure was not followed. Employee #2 reported the suspected abuse was not reported to law enforcement and no witnesses to the alleged physical abuse were interviewed because the facility's Clinical Program Manager thought interviewing patients would be disruptive to the milieu. Employee #2 acknowledged neither employee involved in the	S 320	In further exploring this issue, it was determined that the aerosol machine was malfunctioning causing the nurse to mistakenly assume she was not using it properly. The DON will ensure that nursing staff has the knowledge and training to operate all hospital nursing equipment and will ensure that all nursing equipment is in operating condition. Patient #9's asthma symptoms are presently controlled by the use of an albuterol inhaler 2x per day, and she is medically assessed by the hospital's pediatrician. The aerosol machine is not currently a part of this patient's treatment regime. S 318 - Rights of Patient DWTC has revised policies regarding chemical restraints and are in compliance with NRS 433.5503. DWTC will ensure the protection of rights for all patients in accordance with policies pertinent to patient rights (Reporting of Denial of Rights and Restraint/Seclusion of Patients) (Patients #1, #2, and #3 were discharged; Patients #4, #5, #6, #7, #8, and #9 remain in inpatient treatment at DWTC). Patient rights will be upheld for all patients and monitored by nurse supervisors for compliance, particularly the medical records of Patients #4 - #9. 1. Administration and supervisors enforce policy to ensure patient rights are upheld through clinical meetings, supervision, and shift change. Staff members will consistently follow policies pertinent to patient rights (Reporting of Denial of Rights; Patient Rights; Restraint/Seclusion of Patients). Staff members of DWTC have been informed and will comply with all policies and procedures pertaining to patient rights. State personnel procedures and disciplinary action will follow violations. Policies and procedures regarding chemical restraints have been revised and are in compliance with NRS 433.5503. Staff members of DWTC have been informed and will comply.	09/04/09 10/29/09 10/29/09 10/15/09

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2128HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/27/2009
NAME OF PROVIDER OR SUPPLIER DESERT WILLOW TREATMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6171 W CHARLESTON BLVD, Bldg. #17 LAS VEGAS, NV 89102 89146		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 320	<p>Continued From page 8</p> <p>suspected abuse of the patient was placed on administrative leave following the incident and the patient was never transferred to another program to ensure the patient's proper care and protection.</p> <p>On 8/24/09 at 12:00 PM, an interview was conducted with Employee #8. Employee #8 denied any Conflict Prevention and Response Training (CPART) restraint holds were applied to Patient #1 in the gym on 6/15/09. Employee #8 indicated she and Employee #7 were observing 12 patients in the gym area when she observed Patient #1 yelling at a peer in the gym and asked him to take a time out. Patient #1 started yanking at the railing and at one point started walking towards the door of the gym in an attempt to leave. Patient #1 was verbally redirected to a matted area of the gym. Employee #8 reported the patient complied with verbal directions and at no time were any CPART restraint holds placed on the patient. Employee #8 reported she never physically touched the patient during the redirection. Employee #8 indicated she reported the patient's behavior to the charge nurse once the patients were returned to the unit. Employee #8 reported she had completed a CPART course as part of her facility training and grabbing a patient's arm and twisting it behind his back while restraining the patient against a wall would not be an authorized or approved CPART restraint.</p> <p>A typed incident report from Employee #8 dated 8/1/09 documented an incident on 6/15/09 where Patient #1 displayed verbal aggression toward a certain male peer in the facility gym. Staff intervened and asked Patient #1 to take a time out by asking him to sit on the bleachers. Patient #1 walked over to the bleachers and started yanking at the railing and kicking the bleachers</p>	S 320	<p>Denial of Rights form will be consistently completed and will contain all required information for all chemical restraints, physical restraints, and seclusions.</p> <p>Note: During the September 17, 2009 meeting of the Commission on Mental Health and Developmental Services, this body committed to discuss the Seclusion and Restraint Emergency Procedures form in relation to patient denial of rights at their next meeting scheduled for November 19, 2009. If the intent of the Commission is to continue to utilize the form as a denial of rights, then a request will be made to include "Denial of Rights" in the title of the form. The Commission's authority regarding denial of rights is set forth in NRS 433.534. DWTC will follow the guidance of the Commission and the Attorney General's Office regarding the reporting requirements and the Commission's decisions per their statutory authority.</p> <p>Denial of Rights form will be consistently completed for all patients when on suicide precautions and not able to wear their own clothing or when mattress is placed on the floor of the hall. Administration will also revise Suicide Precautions policy to better clarify and resolve above concerns.</p> <p>The Quality Assurance Specialist has been prioritizing and expediting all incident investigations. DWTC is conducting thorough investigations to ensure patients are protected and free of abuse and/or neglect. Identified staff involved in an investigation are quickly moved to another unit, placed on administrative duties, or placed on administrative leave, depending on severity of incident. All identified witnesses (including patients) are interviewed, and all proper authorities are informed of incident per policy time frames. Report summarizing investigation is completed in an expedited fashion and disseminated to all proper authorities.</p> <p>2. Administration, supervisors, and peer trainers conduct staff in-service/training to ensure patient rights are upheld.</p>	<p>10/29/09</p> <p>11/19/09</p> <p>11/25/09</p> <p>09/08/09</p>

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2128HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/27/2009
NAME OF PROVIDER OR SUPPLIER DESERT WILLOW TREATMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6171 W CHARLESTON BLVD, Bldg. #17 LAS VEGAS, NV 89102 89146		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 320	Continued From page 9 and attempted to walk out of the gym. Staff redirected the patient to a matted wall area where he was given teaching interaction and verbal assurance until he was calm. Patient #1 then returned to the bleachers where he sat until the gym time expired. Patients and staff members then returned to the unit. The incident was reported to Employee #9. A Communication Log entry dated 6/15/09 indicated Patient #1 had verbal and physical aggression telling a male peer to, "shut the (F) up" and refusing to follow instructions, kicking bleachers, yanking railing around on bleachers, yelling at staff." (There was no documentation of a CPART or physical restraint use on the patient.) On 8/25/09 at 1:00 PM, Employee #9 was interviewed regarding the alleged restraint of Patient #1 on 6/15/09 in the facility gym by Employee #7 and Employee #8. Employee #9 reported she was informed about the patient's verbal and physical aggression in the gym by both employees, but was not informed either employee ever restrained the patient. Employee #9 indicated the patient did not complain of shoulder pain when he returned to the unit on 6/15/09 and was not medicated for pain. Employee #9 reported the patient complained of shoulder pain a week later and the physician was called and an x-ray order was obtained for the patient's right shoulder. Employee #9 indicated she was distracted and forgot to write the order for the x-ray in the patients chart. Employee #9 reported, when she questioned Patient #1 about his shoulder pain and injury, he told her that Employee #7 and Employee #8 tried to stop him from leaving the gym on 6/15/09 and grabbed him and held him by his shoulders.	S 320	Retrain staff on Seclusion and Restraint policies (including use of denial of rights). Retrain staff on Incident/Accident Reporting policy. Retrain staff on Patient's Rights policy (including use of denial of rights). Retrain staff on NRS Patient Rights 449.700 - 449.730. Retrain staff on Suicide Precautions policy. 3. Monitor compliance that patient rights are upheld. Mandate review of all policies pertaining to patient rights (annually and upon each revision). Create and institute signed Statement of Understanding of having read, understood, and will adhere to all policies and procedures pertaining to patient rights. Develop database to track signed statements. Rounding Sheet completed by nurse supervisors has been implemented. This includes direct observation of patient rights being upheld on each unit (at least 2x per shift @ random times). If any denial of rights is observed, there will be immediate follow-up of corrective procedures. Rounding Sheet is reviewed daily by DON and CPM II for oversight and compliance. Nurse supervisors receive from unit charge nurses completed Incident/Accident Report, Seclusion and Restraint Emergency Procedures Denial of Rights form, Pain Assessment form, and the Restraint and Seclusion Debriefing & Positive Behavior Intervention Plan for each restraint and seclusion by the end of shift incident occurred. Forms are reviewed for accuracy and	10/29/09 10/29/09 11/25/09 11/25/09 11/25/09 10/29/09 10/29/09 10/15/09 10/08/09 09/21/09

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2128HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/27/2009
NAME OF PROVIDER OR SUPPLIER DESERT WILLOW TREATMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6171 W CHARLESTON BLVD, Bldg. #17 LAS VEGAS, NV-89102 89116		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 320	<p>Continued From page 10</p> <p>A Nursing Progress Note dated 6/15/09 at 8:21 PM, by Employee #9 indicated Patient #1 took part in all unit activities with a flat affect and labile mood. "Attended, participated during fitness group, and played volleyball at the gym. He had a good appetite for dinner and snack. He had a positive phone call from mom. Took evening medication with no adverse reaction noted. Staff will continue to monitor for patient safety and comfort. Had VA (verbal aggression) PA (physical aggression) telling certain male peer to "shut the f up". Refused to comply with staff's instructions, dramatic, negative attention seeking behavior, kicking bleachers, yanking railing, around on bleachers, yelling at staff, teaching interaction done with fair acceptance to feedback."</p> <p>A typed statement of the incident dated 8/2/09 from Employee #9 documented no takedown on Patient #1 was reported by Employee #7 or Employee #8. "The patient was just escorted against the wall and given teaching interaction to help calm him down. The patient reported he was taken down a week after the incident. I did not believe him because all the while he was playing volleyball without complaining of any pain. When it was time for fitness group he complained of shoulder pain only before fitness group. Thus x-ray was done to validate his complaint which came out negative."</p> <p>On 8/25/09 at 3:00 PM, an interview was conducted with Employee #7 who denied any CPART holds were applied to Patient #1 on 6/15/09 in the gym area of the facility. Employee #7 reported the patient was exhibiting verbal and physical aggression and was yelling at a peer and kicking the bleachers and pulling on the railing in the gym. The patient attempted to leave the gym area and she blocked his path while Employee #8</p>	S 320	<p>completeness, including the completion of a denial of rights form for patients on suicide precautions and not able to wear their own clothing or when mattress is placed on the floor of the hall. If any error is detected, there will be immediate follow-up of corrective action. Forms are submitted daily to DON for review and oversight.</p> <p>The Quality Assurance Specialist tracks consumer complaints pertaining to violations of patient rights. Any consumer complaint related to denial of rights will be immediately investigated. Report of investigation is submitted to CPM II for corrective action.</p> <p>The CPM II will monitor and ensure that the Quality Assurance Specialist conducts thorough investigations after incidents to make certain all patients are protected and free of abuse and/or neglect.</p> <p>S 320 - Protection of Patient</p> <p>DWTC will revise and execute policies and procedures that prevent and prohibit verbal, sexual, physical, and mental abuse of all patients (Patient #1 was discharged; Patients #8 and #9 remain in inpatient treatment at DWTC). The protection of all patients will be upheld and monitored by administration, nursing supervisors, the Quality Assurance Department, and the Behavior Management Team.</p> <p>1. Revision of policies and procedures pertaining to restraints/seclusion and abuse/neglect for heightened clarity and for the protection of all patients.</p> <p>Revise Incident/Accident Reporting policy and Restraint/Seclusion of Patients policy to clearly specify that charge nurse on each unit is responsible for the documentation and completion of Incident/Accident Report, Seclusion and Restraint Emergency Procedures Denial of Rights form, Pain Assessment form, and the Restraint and Seclusion Debriefing & Positive Behavior</p>	<p>09/25/09</p> <p>09/08/09</p> <p>10/29/09</p> <p>10/15/09</p>	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2128HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/27/2009
NAME OF PROVIDER OR SUPPLIER DESERT WILLOW TREATMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6171 W CHARLESTON BLVD, Bldg. #17 LAS VEGAS, NV 89102 89146		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 320	<p>Continued From page 11</p> <p>positioned herself on the opposite side of the patient. The patient was verbally directed to a padded area of the gym. Employee #7 reported at no time did she or Employee #8 place the patient in a CPART hold or physically place their hands on the patient. Employee #7 indicated she had completed a CPART course as part of her facility training and twisting a patients arm behind his back and restraining the patient against a wall would not be an approved or authorized CPART hold.</p> <p>A typed incident report dated 8/14/09, by Employee #7 documented Patient #1 was playing volleyball with his peers and got angry at a fellow peer and yelled, "shut the f up. "Employee #7 and Employee #8 intervened and asked the patient to take a time out asking him to sit on the bleachers. "The patient stomped over to the bleachers and started yanking at the railing and kicking the bleachers. The patient attempted to walk out of the gym. Employee #7 stood in front of the gym door. Both employees then redirected and accompanied the patient to the matted area away from the door. Teaching interactions were were given to the patient to calm down and take deep breaths. The above behavior was reported to the R.N."</p> <p>On 8/26/09 at 11:35 AM, an interview was conducted with Patient #4. Permission to interview the patient was obtained from the patient's father prior to the interview. Employee #6, the patients therapist was present during the interview. Patient #4 reported he remembered the incident on 6/15/09 that took place in the gym area of the facility. Patient #4 reported the incident occurred at 7:00 PM while the patients were playing volley ball. Patient #4 reported Patient #1 became agitated and angry and</p>	S 320	<p>Intervention Plan by the end of shift incident occurred.</p> <p>Revise Incident/Accident Report policy to include types of physical restraint used, chemical restraint, and locked/unlocked seclusion.</p> <p>Revise Progress Notation policy to clearly specify that Mental Health Technicians will document in progress notes any restraint for which they may be involved by the end of shift incident occurred.</p> <p>Revise Reporting and Investigation of Abuse and/or Neglect of Patients policy to heighten clarity and to mirror NRS 432B.</p> <p>2. Reviewed and revised CPART certification and recertification courses to ensure the protection of all patients.</p> <p>Increase practice and role modeling (return demonstration) of approved CPART holds.</p> <p>Increase the preventive techniques and de-escalation content (proactive intervention) within CPART certification and recertification training.</p> <p>3. Administration and supervisors enforce policy to ensure the protection of all patients through clinical meetings, supervision, and shift change.</p> <p>Any physical or chemical restraint will be prescribed by a physician order.</p> <p>The use of any physical or chemical restraint will result in reporting the incident as a denial of rights, using appropriate form.</p> <p>Any physical or chemical restraint will be documented in patients' medical record and through the use of an Incident/Accident Report, Seclusion and Restraint Emergency Procedures Denial of Rights form, Pain Assessment form, and the Restraint and Seclusion Debriefing & Positive</p>	<p>10/15/09</p> <p>10/15/09</p> <p>11/25/09</p> <p>09/30/09</p> <p>09/30/09</p> <p>09/04/09</p> <p>09/04/09</p> <p>09/04/09</p>	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2128HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/27/2009
NAME OF PROVIDER OR SUPPLIER DESERT WILLOW TREATMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6171 W CHARLESTON BLVD, Bldg. #17 LAS VEGAS, NV -89402 89146		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 320	<p>Continued From page 12</p> <p>verbally yelled at him to "Shut the (F) up." Patient #4 reported at one point Patient #1 attempted to run out of the gym and was physically restrained by both Employee #7 and Employee #8. Patient #4 reported both employees grabbed Patient #1 by the shoulders and twisted his arm behind his back and pushed him up against a wall in the gym. Patient #4 estimated both employees restrained Patient #1 against the wall for approximately 15 seconds before having him sit on the bleachers.</p> <p>On 8/26/09 at 11:45 AM, an interview was conducted with Patient #2. Permission to interview the patient was obtained from the patient's mother prior to the interview. Employee #6, the patient's therapist, was present during the interview. Patient #2 reported he remembered the incident on 6/15/09, that took place in the facility gym. Patient #2 reported the incident took place in the evening between 7:15 PM and 8:00 PM while the patients were playing volleyball. Patient #2 reported Patient #1 became involved in a verbal argument with another patient and yelled, "Shut the (F) up." Patient #2 indicated Patient #1 was angry and agitated and at one point ran for the door of the gym. Patient #2 reported Employee #7 and Employee #8 both grabbed Patient #1, put his arm behind his back, and slammed him up against a wall in the gym. Patient #2 indicated Patient #1 was restrained by both employees against the wall for approximately 4 to 5 minutes.</p> <p>The facility June 2009 and July 2009 Restraint/Seclusion Log indicated there were no documented incidents of physical restraint or seclusion for Patient #1 on 06/15/09 or for the months of March 2009, April 2009, May 2009, June 2009, and July 2009.</p>	S 320	<p>Behavior Intervention Plan.</p> <p>Any suspected abuse/neglect will be reported to proper authorities (CPM II, DCFS Deputy Administrator, law enforcement, Child Protective Services, Bureau of Health Care Quality and Compliance) within 24 hours.</p> <p>Internal investigation of incident by Quality Assurance Specialist will be expedited.</p> <p>Identified staff involved in an abuse/neglect investigation are quickly moved to another unit, placed on administrative duties, or placed on administrative leave, depending on severity of incident.</p> <p>All identified witnesses (including patients) are interviewed.</p> <p>Report summarizing investigation is completed in an expedited fashion and disseminated to all proper authorities.</p> <p>4. Administration, supervisors, and peer trainers conduct staff in-service/training for the protection of all patients.</p> <p>Retrain staff on Incident/Accident Reporting policy (including accurately documenting all persons involved in incident).</p> <p>Retrain staff on Seclusion and Restraint policies (including use of denial of rights and obtaining physician order).</p> <p>Retrain staff on NAC 449.3628 – Protection of Patients.</p> <p>Retrain nursing staff on required documentation of patient injury and any medical care provided.</p> <p>Retrain staff on approved CPART holds, preventive techniques, and de-escalation skills.</p>	<p>09/08/09</p> <p>09/08/09</p> <p>09/08/09</p> <p>09/08/09</p> <p>09/08/09</p> <p>10/29/09</p> <p>10/29/09</p> <p>10/29/09</p> <p>10/29/09</p> <p>10/29/09</p>	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2128HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/27/2009
NAME OF PROVIDER OR SUPPLIER DESERT WILLOW TREATMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6171 W CHARLESTON BLVD, Bldg. # 17 LAS VEGAS, NV 89102 89146		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 320	Continued From page 13 A review of Physicians Orders for Patient #1 failed to reveal evidence of a physician order for physical restraints on 6/15/09, the date of the alleged incident. A Communication Log entry dated 6/21/09 indicated an x-ray on the patient's right shoulder was completed. The x-ray was negative for fracture or dislocation. The facilities Restraint Seclusion Policy last revised 07/06 indicated restraint and seclusion shall only be used in an emergency safety measure in situations of imminent danger to patients, staff or others when less restrictive measures have been or likely to be ineffective in averting danger. Steps outlined in the procedure for restraint and seclusion included the following: 1. "Physician written or verbal orders for initial and continued use of restraints are required and are time limited and are not written as PRN orders." 2. "The nurse will conduct a face to face assessment of the patients status immediately following restraint or seclusion." 3. "Designated parents/guardians shall be notified of each occurrence of restraint and seclusion with a time frame not to exceed 24 hours." 4. "The nurse will initiate a debriefing following each episode of restraint and seclusion no longer than 24 hours after the episode in order to review the event and plan any future, earlier alternative interventions. The staff member will document in	S 320	Retrain staff on documentation to medical necessity, objective facts of incident, behavioral descriptors, precipitating factors, description of interventions prior to restraint, and type and description of CPART hold. Retrain staff on Reporting and Investigation of Abuse and/or Neglect of Patients policy. 5. Monitor compliance that patient safety and protection is upheld for all patients. Mandate review of all policies pertaining to restraints and abuse/neglect to ensure the protection of all patients. Create and institute signed Statement of Understanding of having read, understood, and will adhere to all policies and procedures pertaining to restraints and abuse/neglect. Develop database to track signed statements. Rounding Sheet completed by nurse supervisors has been implemented. This includes direct observation of restraints and to ensure that the protection of all patients is upheld on each unit (at least 2x per shift @ random times). If any safety issue is observed, there will be immediate follow-up of corrective procedures. Rounding Sheet is reviewed daily by DON and CPM II for oversight and compliance. Nurse supervisors receive from unit charge nurses completed Incident/Accident Report, Seclusion and Restraint Emergency Procedures Denial of Rights form, Pain Assessment form, and the Restraint and Seclusion Debriefing & Positive Behavior Intervention Plan for each restraint and seclusion by the end of shift incident occurred. Forms are reviewed for accuracy and completeness. If any error is detected, there will be immediate follow-up of corrective action. Forms are submitted daily to DON for review and oversight.	10/29/09 11/25/09 11/25/09 11/25/09 10/15/09 10/08/09 09/21/09

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2128HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/27/2009
NAME OF PROVIDER OR SUPPLIER DESERT WILLOW TREATMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6171 W CHARLESTON BLVD, Bldg. #17 LAS VEGAS, NV-89102 89146		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
S 320	<p>Continued From page 15</p> <p>The facility failed to follow policy and procedure by not placing the employees involved in the abuse allegation on administrative leave pending completion of the investigation.</p> <p>A review of the facility CPART training records revealed both employees CPART certification was valid until 6/12/10.</p> <p>A review of the facilities CPART training manual last revised 01/05 failed to reveal documented CPART restraint holds that involved twisting a patients arm behind the back and restraining a patient against a wall.</p> <p>A review of Patient #1's medical record and staffing schedules revealed Employee #7 and Employee #8 continued to have frequent contact with the patient and be involved in the care and treatment of the patient following the physical abuse restraint incident on 06/15/09 and until the patient's discharge from the facility on 7/23/09.</p> <p>The Facilities Report and Investigation of Abuse and or Neglect of Patients Policy and Procedure last revised 12/07 included the following:</p> <p>1. Policy: "Physical abuse and/or neglect of patients is unlawful and will not be condoned or allowed in any Division program. Suspected abuse or neglect is to be immediately reported to the supervisor and Clinical Program Manager II." "Abuse and neglect means the non-accidental physical or mental injury, sexual abuse, negligent treatment or maltreatment of an individual under circumstances which indicate that the individual's health or welfare is harmed or threatened thereby."</p> <p>2. Procedure: The Clinical Program Manager II,</p>	S 320	<p>Patient #9 will continue to be monitored for safety.</p> <p>As noted previously, Patient #8 remains in inpatient treatment at DWTC. He has been transferred to another unit since the 8/13/09 CPART hold. Results of investigation remain pending. Patient #8 will continue to be monitored for safety. Staff members have been retrained on least restrictive interventions, de-escalation techniques, and clear documentation to medical necessity, objective facts of incident, behavioral descriptors, precipitating factors, description of interventions prior to restraint, and type and description of CPART hold. Any current discrepancies with unjust/unnecessary intervention or inappropriate documentation will be submitted to the Quality Assurance Specialist for further review or investigation.</p>		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2128HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/27/2009
NAME OF PROVIDER OR SUPPLIER DESERT WILLOW TREATMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6171 W CHARLESTON BLVD, Bldg. #17 LAS VEGAS, NV 89102 89146		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 320	<p>Continued From page 16</p> <p>or person acting in that capacity upon receiving a report of alleged abuse or neglect will take the following actions:</p> <p>a. "As soon as possible, but within 24 hours of being apprised of suspected abuse or neglect, notify the law enforcement agency with jurisdiction over the incident."</p> <p>b. "Immediately, but in no case longer than 24 hours, notify the Deputy Administrator, Division of Child and Family Services, or the person acting in that capacity, of the incident."</p> <p>c. "As soon as possible, but within 24 hours, notify the patient legal guardian, if one has been appointed of the incident. Notify Child Protective Services."</p> <p>d. "As soon as practical, separately interview witnesses, the alleged victim, and the alleged perpetrator for the purpose of ascertaining the need for immediate action to prevent further abuse or neglect."</p> <p>e. "If the Clinical Program Manager II initially finds physical evidence and /or corroboration witnesses of the reported abuse and neglect, he/she shall notify the appropriate law enforcement agency."</p> <p>f. "If upon preliminary investigation, the Clinical Program Manager II determines the facts surrounding the alleged incident provide reason to believe that the patient is in danger of continued or repeated abuse or neglect, immediate action shall be taken which may include:</p> <ol style="list-style-type: none"> 1. "Placing the alleged perpetrator on administrative leave." 2. "Transferring the patient or staff to another program within the agency to ensure the patient's proper care and protection." 	S 320			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2128HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/27/2009
NAME OF PROVIDER OR SUPPLIER DESERT WILLOW TREATMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6171 W CHARLESTON BLVD, Bldg. #17 LAS VEGAS, NV 89102 89146		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 320	Continued From page 17 Complaint #NV00022688 Patient #9 Patient #9 was re-admitted to the facility on 7/1/09 with diagnoses including mood disorder, conduct disorder, alcohol abuse, marijuana abuse, history of asthma and severe constipation. On 7/28/09, an allegation was made by Patient #9 of a staff member poking her in the chest. The Las Vegas police unsubstantiated the allegation of physical and sexual abuse. The facility failed perform an internal investigation per their Reporting and Investigation of Abuse and/or Neglect of Patients. Complaint #NV00022683 Patient #8 Patient #8, a 12 year old male, was admitted on 8/7/09, with a diagnosis of mood disorder. The facility failed to have evidence of an investigation of the implementation of a CPART hold on 8/13/09, after the DON documented "Charge RN was informed this CPART may have been unnecessary when the child only postured, no actual assault." A day later the patient complained of pain in the right shoulder blade. Severity: 3 Scope: 1	S 320	S 325 – Physical Restraint Use DWTC will ensure that all policies and procedures pertaining to the use of physical restraints are upheld for all patients (Patient #1 was discharged; Patients #5, #6, #7, #8, and #9 remain in inpatient treatment at DWTC). Nurse supervisors and the Quality Assurance Specialist will monitor compliance with the use of physical restraints for all patients, particularly the medical records of Patients #5 - #9. 1. Administration and supervisors enforce policy to ensure the use of physical restraints are executed properly through clinical meetings, supervision, and shift change. Any physical restraint will be prescribed by a physician order. The use of any physical restraint will result in reporting the incident as a denial of rights, using appropriate form. All patients are treated and managed in the least restrictive manner. Physical restraint will only be used as an emergency safety measure in situations of imminent danger to patients, staff, or others and when less restrictive interventions have been determined to be ineffective to protect the patient or others from harm. Nursing staff completes a post intervention assessment as well as a pain assessment immediately following a physical restraint, and all items on the forms and within the Restraint/Seclusion of Patients policy are thoroughly documented and completed.	09/04/09 09/04/09 09/04/09 10/29/09
S 325 SS=I	NAC 449.3628 Physical Restraint Use 5. The governing body shall ensure that the use of any physical restraints on a patient is initiated only pursuant to a physician's order or protocols approved by the medical staff and the hospital administration. This Regulation is not met as evidenced by:	S 325	Any physical or chemical restraint will be documented in patient's medical record and through the use of an Incident/Accident Report, Seclusion and Restraint Emergency Procedures Denial of Rights form, Pain Assessment form, and the Restraint and Seclusion Debriefing & Positive Behavior Intervention Plan.	09/04/09

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2128HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/27/2009
NAME OF PROVIDER OR SUPPLIER DESERT WILLOW TREATMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6171 W CHARLESTON BLVD, Bldg. #17 LAS VEGAS, NV 89402 89146		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 325	<p>Continued From page 18</p> <p>Based on interview, record review and document review the facility failed to ensure the use of physical restraints on patients was initiated pursuant to physician's order and facility policy (Restraint/Seclusion of Patients policy #8.03 dated 1/1/2005 and reviewed on 7/2006, Reporting of Denial of Rights #2.02 effective 1/1/2005 and revised on 12/2007, and Report and Investigation of Abuse and or Neglect of Patients last revised 12/07) for 6 of 11 patients (Patients #1, #5, #6, #7, #8, #9).</p> <p>Interviews throughout the survey with the mental health technicians and review of the CPART (Conflict Prevention Response Training) training manual revealed staff were to utilize the least restrictive measures.</p> <p>The DON reported that, after a CPART hold, the RN does a "pain assessment." She reported they do not document all items as identified in the Restraint/Seclusion of Patients policy.</p> <p>Patient #7</p> <p>Patient #7, a 15 year old male, was admitted on 7/10/09, with the diagnoses that included depressive disorder, history of psychotic disorder, history of impulse disorder, and history of oppositional defiant disorder.</p> <p>On 7/11/09 at 11:27 AM, a physician's order read "physical restraint up to 2 hours for physical aggression..." The facility failed to have evidence of an Incident/Accident report, assessment, nor Denial of Rights (DOR) for this incident.</p> <p>On 7/24/09 at 5:45 PM, an incident report documented a "10 minute CPART hold." The facility failed to have evidence of a DOR for this</p>	S 325	<p>Seclusion monitoring is performed through continuous, in-person observation for the first hour a patient is in seclusion. After the first hour, the patient may be monitored using video if consistent with the patient's condition. Seclusion monitoring is documented in the patient's medical record and on the 15-Minute Observation Monitoring form. Patients who are in seclusion are regularly re-evaluated every two hours for children ages 9 and older and every hour for children under age 9.</p> <p>Patients who have been restrained or secluded and staff members who have participated in these interventions will engage in debriefing each episode to elicit feedback and information from the patient and staff about the intervention and to plan for future, earlier, or alternative interventions.</p> <p>2. Administration, supervisors, and peer trainers conduct staff in-service/training to ensure use of restraints and seclusion are properly upheld.</p> <p>Retrain staff on Restraint and Seclusion policies (including use of denial of rights).</p> <p>Retrain staff on Incident/Accident Reporting policy.</p> <p>Retrain staff on approved CPART holds, preventive techniques, and de-escalation skills.</p> <p>Retrain staff on documentation to medical necessity, objective facts of incident, behavioral descriptors, precipitating factors, description of interventions prior to restraint, and type and description of CPART hold.</p> <p>3. Monitor compliance that proper use of restraints and seclusion are upheld.</p> <p>Mandate review of all policies pertaining to restraints and seclusion (annually and upon each revision).</p>	<p>10/29/09</p> <p>09/04/09</p> <p>10/29/09</p> <p>10/29/09</p> <p>10/29/09</p> <p>10/29/09</p> <p>10/29/09</p>	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2128HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/27/2009
NAME OF PROVIDER OR SUPPLIER DESERT WILLOW TREATMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6171 W CHARLESTON BLVD , Bldg. #17 LAS VEGAS, NV 89142 89146		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 325	<p>Continued From page 19</p> <p>incident or a physician's order for the hold.</p> <p>On 7/26/09 at 11:00 AM, an incident report documented a "2 minute CPART hold." The facility did not produce a DOR for this incident or a physician's order for the CPART hold.</p> <p>On 7/27/09 at 11:40 AM, a physician's order for a "therapeutic hold" was documented. The facility did not produce an Incident/Accident report, assessment, nor DOR for this incident.</p> <p>On 7/27/09 at 4:30 PM, a physician's order for "CPART hold for at least 30 minutes to keep safe" was documented. The RN notes documented the CPART hold occurred. The facility did not produce an Incident/Accident report, assessment, nor DOR for this incident.</p> <p>On 8/9/09 8:05 PM, an incident report documented a "CPART hold..." The facility did not produce a DOR for this incident.</p> <p>Patient #8</p> <p>Patient #8, a 12 year old male, was admitted on 8/7/09, with a diagnosis of mood disorder.</p> <p>A mental health technician (MHT) progress note written on 8/13/09, read "I will show you and postured at the nurse!! To hit him and was place in CPART hold for 7 minutes." An RN progress note written on 8/13/09 read "He refused to go to Quiet Room, then he postured to hit staff with a closed fist. CPART hold was implemented. Dr. was made aware of the incident..." A physician's order dated 8/13/09 at 4:45 PM read "CPART hold for physical aggression..."</p> <p>The Incident report documented "Action Taken:</p>	S 325	<p>Create and institute signed Statement of Understanding of having read, understood, and will adhere to all policies and procedures pertaining to restraints and seclusion.</p> <p>Develop database to track signed statements.</p> <p>Rounding Sheet completed by nurse supervisors has been implemented. This includes direct observation of the use of restraints and seclusion on each unit (at least 2x per shift @ random times). If any violation of the policies or procedures is observed, there will be immediate follow-up of corrective procedures. Rounding Sheet is reviewed daily by DON and CPM II for oversight and compliance.</p> <p>Nurse supervisors receive from unit charge nurses completed Incident/Accident Report, Seclusion and Restraint Emergency Procedures Denial of Rights form, Pain Assessment form, and the Restraint and Seclusion Debriefing & Positive Behavior Intervention Plan for each restraint and seclusion by the end of shift incident occurred. Forms are reviewed for accuracy and completeness. If any error is detected, there will be immediate follow-up of corrective action. Forms are submitted daily to DON for review and oversight.</p> <p>The Quality Assurance Specialist will compare patient progress notes with database that contains all submitted Incident/Accident Reports and Restraints/Seclusions for accurately capturing and appropriately documenting all incidents. Twenty patient cases will be randomly selected per quarter. Discrepancies will be brought to the attention of the CPM II within one business day for further investigation and corrective action if necessary.</p> <p>The Behavior Management Team provides additional oversight of Incident/Accident Report, Seclusion and Restraint Emergency Procedures Denial of Rights form, Pain Assessment form, and the Restraint and Seclusion Debriefing & Positive Behavior Intervention Plan. The team meets weekly to review completed forms and monitors</p>	<p>10/29/09</p> <p>10/15/09</p> <p>10/08/09</p> <p>09/21/09</p> <p>09/16/09</p> <p>10/12/09</p>	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2128HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/27/2009
NAME OF PROVIDER OR SUPPLIER DESERT WILLOW TREATMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6171 W CHARLESTON BLVD Bldg. #17 LAS VEGAS, NV 89146		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 325	<p>Continued From page 20</p> <p>CPART hold.... On initial assessment the patient denied pain. A day later the patient claimed of pain in the right shoulder blade. No swelling nor limitation of movement on the involved extremity. He was given Ibuprofen for pain." The DON wrote in the comment section "Charge RN was informed this CPART may have been unnecessary when the child only postured, no actual assault."</p> <p>The debriefing was completed. Documentation indicated the "child could have controlled his anger." There was no documented evidence of a discussion of the possibility of an unnecessary CPART and what the staff could have done differently. There was no "Denial of Rights" completed for the CPART hold.</p> <p>Patient #5</p> <p>Patient #5, a 16 year old female, had a current admit date on 6/24/09 and a previous admission on 5/7/09. Her diagnoses included bipolar disorder, mixed, severe psychosis, eating disorder, and post traumatic stress disorder.</p> <p>On 5/11/09 at 11:28 AM, an incident documented that a "Therapeutic Hold" was done between 11:28 AM and 11:32 AM.</p> <p>On 5/20/09 at 7:00 PM an incident was recorded as a "5 min CPART hold." The facility failed to have evidence of a physician's order for the CPART hold.</p> <p>On 7/30/09 at 4:00 PM an incident was recorded as a "5 min CPART hold." The facility failed to have evidence of a physician's order for the CPART hold.</p>	S 325	<p>for necessity of intervention, appropriate documentation, and whether actions were justified. Any form found with unjust/unnecessary intervention or inappropriate documentation will be returned to the Quality Assurance Specialist for further review or investigation</p>	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2128HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/27/2009
NAME OF PROVIDER OR SUPPLIER DESERT WILLOW TREATMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6171 W CHARLESTON BLVD, Bldg. #17 LAS VEGAS, NV 89102 89116		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
S 325	<p>Continued From page 21</p> <p>Patient #6</p> <p>Patient #6, a 15 year old male, was admitted on 2/2/09, with the diagnosis of psychotic disorder.</p> <p>On 7/13/09 at 3:55 AM a physician's order read "Place in locked seclusion for up to 1 hour for safety." An incident was recorded on 7/13/09 at 3:25 AM and read "was in seclusion for 30 minutes." A daily 15 minute "Unit Where About Sheet" was presented by the facility as a "Restraint Monitoring" sheet.</p> <p>The Quality Assurance Specialist (QA) reported the "Unit Where About Sheet" was used when monitoring the "Seclusion" room. The form was blocked into in 15 minute increments. The QA reported the staff document "QR" when a patient was in seclusion. She indicated "QR" stood for Quiet Room. She stated the staff also use "QR" when the patient is in the quiet room when the door is unlocked.</p> <p>Review of the the 7/13/09, "Unit Where About Sheet" revealed Patient #6 was in the "QR" from 3:45 AM to 5:15 AM. The 7/13/09 "Unit Where About Sheet" indicated the patient was listed as "QR" in the 8:00 PM section and "QR" in the 8:45 PM to 10:45 PM time sections.</p> <p>The facility failed to have documented evidence "continuous in-person monitoring" occurred for Patient #6.</p> <p>On 7/13/09 at 8:30 PM, an incident was recorded as a "3 person CPART hold..." and on 7/31/09 at 8:10 PM an incident indicated a "CPART hold." The facility did not have evidence of a physician's order for the CPART holds.</p>	S 325			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2128HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/27/2009
NAME OF PROVIDER OR SUPPLIER DESERT WILLOW TREATMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6171 W CHARLESTON BLVD, Bldg. #17 LAS VEGAS, NV 89102 89146		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
S 325	<p>Continued From page 22</p> <p>Patient #1</p> <p>Patient #1 was a 13 year old white juvenile admitted to the facility on 02/03/09 with a diagnosis that included bipolar disorder, oppositional defiant disorder and impulse control disorder. The patient was discharged from the facility on 07/23/09. A Physicians Discharge Summary dated 07/23/09 indicated the patient struggled throughout the time in the residential program. On admission the patient was extremely oppositional and labile. Several outbursts required physical holds including the day of admission.</p> <p>A Residential Treatment Center Services Continued Stay Request Note dated 04/15/09 and 06/15/09 indicated the patient was physically restrained for aggressive and violent behaviors on the following dates:</p> <ol style="list-style-type: none"> 1. 02/03/09 - Physical restraint for aggressive violent behaviors. 2. 02/09/09 - Physical restraint for violent behaviors and attempting to harm staff. 3. 04/13/09 - Physical restraint for aggressive behaviors and attempting to harm staff. 4. 06/15/09 - Physical restraint for aggressive behavior towards a peer. 5. A Nursing progress Note dated 6/17/09 at 1:07 PM, indicated the patient was placed in a physical restraint for being verbally and physically aggressive. <p>A review of Physician Orders from the date of admission on 2/3/09 to the date of discharge on</p>	S 325			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2128HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/27/2009
NAME OF PROVIDER OR SUPPLIER DESERT WILLOW TREATMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6171 W CHARLESTON BLVD, Bldg. #17 LAS VEGAS, NV 89102 89146		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 325	<p>Continued From page 23</p> <p>7/23/09 revealed one documented physician order for physical restraint for aggressive and violent behavior on 2/3/09. There were no other documented physician orders for restraint use.</p> <p>On 8/24/09 at 4:00 PM, Employee #2 acknowledged there was no documented physician's orders in the medical record for physical restraint use on the patient for 2/9/09, 4/13/09, 6/15/09 and 6/17/09 per facility policy. Employee #2 acknowledged there was no Restraint Incident Reports or Denial of Rights Forms for physical restraint use on Patient #1 for 2/9/09, 4/13/09, 6/15/09 and 6/17/09 per facility policy.</p> <p>The facility Restraint Seclusion Policy last revised 07/06 indicated restraint and seclusion shall only be used in an emergency safety measure in situations of imminent danger to patients, staff or others when less restrictive measures have been or likely to be ineffective in averting danger.</p> <p>Patient #9</p> <p>Patient #9 was initially admitted on 2/27/09 with the diagnoses that included depressive disorder, post traumatic stress disorder, significant allergies, history of seizures, and history of asthma. Patient #9 was re-admitted to the facility on 7/1/09 with diagnoses including mood disorder, conduct disorder, alcohol abuse, marijuana abuse, history of asthma, and severe constipation.</p> <p>On 8/7/09 at 4:55 PM, a physician's order was received to "Place patient in seclusion for homicidality toward peers." The facility did not produce a DOR or an assessment of the patient for this incident. The facility did not produce</p>	S 325			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2128HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/27/2009
NAME OF PROVIDER OR SUPPLIER DESERT WILLOW TREATMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6171 W CHARLESTON BLVD, Bldg. #17 LAS VEGAS, NV 89102 89146		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 328	Continued From page 25 Based on interview, record review and document review the facility failed to consistently follow the facility restraint policy and procedure and notify a physician within 12 hours after the use of a physical restraint for 5 of 11 patients. (Patients #1, #5, #6, #7, and #8) Complaint #NV00022688 Severity: 2 Scope: 2	S 328	Mandate review of all policies pertaining to physical restraints (annually and upon each revision). Create and institute signed Statement of Understanding of having read, understood, and will adhere to all policies and procedures pertaining to physical restraints. Develop database to track signed statements.	10/29/09 10/29/09 10/15/09
S 329 SS=E	NAC 449.3628 Physical Restraint Use 6. If the use of physical restraints is permitted pursuant to approved protocols, the approved protocols must include: (d) A requirement that a verbal or written order of the physician be obtained and entered into the medical record of the patient This Regulation is not met as evidenced by: Based on document review and record review the facility nursing staff failed to consistently obtain verbal or written physician orders for all instances of restraint use and document the orders in the patients medical records for 5 of 11 patients. (Patients #1, #5, #6, #7, #9) Complaint #NV00022688 Severity 2 Scope 2	S 329	Rounding Sheet completed by nurse supervisors has been implemented. This includes direct observation of the use of physical restraints on each unit (at least 2x per shift @ random times). Nurse supervisors will monitor medical records for obtained physician order within one hour after the initiation of a physical restraint. If any violation of the policy or procedures is observed, there will be immediate follow-up of corrective procedures. Rounding Sheet is reviewed daily by DON and CPM II for oversight and compliance. Nurse supervisors receive from unit charge nurses completed Incident/Accident Report, Seclusion and Restraint Emergency Procedures Denial of Rights form, Pain Assessment form, and the Restraint and Seclusion Debriefing & Positive Behavior Intervention Plan for each restraint and seclusion by the end of shift incident occurred. Forms are reviewed for accuracy and completeness. If any error is detected, there will be immediate follow-up of corrective action. Forms are submitted daily to DON for review and oversight.	10/08/09 09/21/09
S 332 SS=F	NAC 449.3628 Physical Restraint Use 8. The hospital shall have a process for quality improvement to identify appropriate opportunities for reducing the use of physical restraints. The process for quality improvement must include areas for measurement and assessment to	S 332	Nurse supervisors under the direction of the DON will conduct monthly medical record audits to monitor use of restraints and seclusion, physician orders obtained and documented , length of restraints and seclusion, medications administered and documented, reasons and results of medication documented in MAR, patient/staff injury, denial of rights, debriefing, post intervention assessment, pain assessment, content of patient progress notes, etc. Audit information will be submitted to the Quality Assurance Department for assessment.	11/20/09

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

STATE FORM

6899

HPKN11

If continuation sheet 26 of 35

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2128HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/27/2009
NAME OF PROVIDER OR SUPPLIER DESERT WILLOW TREATMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6171 W CHARLESTON BLVD, Bldg. #17 LAS VEGAS, NV 89102 89146		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 332	Continued From page 26 identify opportunities to reduce the risks associated with the use of physical restraints through the introduction of preventive strategies, innovative alternatives to the use of physical restraints and improvements to the process of using physical restraints. This Regulation is not met as evidenced by: Based on interview, document review and chart review the facility failed to ensure an effective process through quality assurance for reducing the use restraints through the introduction of preventative strategies and the provision on innovative alternatives and failed to have a plan to reduce the number of physical and chemical restraints. Severity: 2 Scope: 3	S 332	Data will be presented to monthly LET meetings for quality and program improvement. S 329 – Physical Restraint Use DWTC will consistently obtain verbal or written physician orders for all instances of restraint use and document the orders in the patients' medical records (Patient #1 was discharged; Patients #5, #6, #7, and #9 remain in inpatient treatment at DWTC). Nurse supervisors will monitor compliance with the use of restraints for all patients, particularly the medical records of Patients #5, #6, #7, and #9. 1. Administration and supervisors enforce policy to ensure the use of restraints are executed and documented properly through clinical meetings, supervision, and shift change. As soon as possible, but no longer than one hour after the initiation of a restraint, the RN notifies and obtains an order (verbal or written) from the physician and documents order in medical record.	09/04/09
S 602 SS=1	NAC 449.394 Psychiatric Services 3. A hospital shall develop and carry out policies and procedures for the provision of psychiatric treatment and behavioral management services that are consistent with NRS 449.765 to 449.786, inclusive, to ensure that the treatment and services are safely and appropriately used. The hospital shall ensure that the policies and procedures protect the safety and rights of the patient. This Regulation is not met as evidenced by: Based on staff interview and record review, the facility failed to monitor and assess the administration of a chemical restraint and failed to complete a Denial of Rights in accordance with facility policy Restraint/Seclusion of Patients policy #8.03 dated 1/1/2005 and reviewed on 7/2006 for 5 of 11 patients. (Patients #5, #6, #7, #8, and #9)	S 602	2. Administration, supervisors, and peer trainers conduct staff in-service/training to ensure use and documentation of restraints are properly upheld. Retrain staff on Restraint/Seclusion of Patients policy. Retrain staff on Incident/Accident Reporting policy. 3. Monitor compliance that use and documentation of restraints are properly upheld. Mandate review of all policies pertaining to restraints (annually and upon each revision). Create and institute signed Statement of Understanding of having read, understood, and will adhere to all policies and procedures	10/29/09 10/29/09 10/29/09 10/29/09

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2128HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/27/2009
NAME OF PROVIDER OR SUPPLIER DESERT WILLOW TREATMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6171 W CHARLESTON BLVD, Bldg. #17 LAS VEGAS, NV 89102 89146		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 602	<p>Continued From page 27</p> <p>Patient #9</p> <p>Patient #9 was initially admitted on 2/27/09 with the diagnoses that included depressive disorder, post traumatic stress disorder, significant allergies, history of seizures, and history of asthma. Patient #9 was re-admitted to the facility on 7/1/09 with diagnoses including mood disorder, conduct disorder, alcohol abuse, marijuana abuse, history of asthma, and severe constipation.</p> <p>On 7/13/09 at 5:35 PM, a physician's order was received for "Ativan 2 mg IM STAT for increase anxiety per patient request." The facility did not produce a DOR for a chemical restraint or an assessment of Patient #9 for this incident.</p> <p>On 7/13/09 at 6:30 PM, a physician's order was received for "Benadryl 50 mg IM now for increase anxiety. And may give another dose of Ativan 2 mg IM if patient still anxious/agitated." The facility failed to produce a DOR for a chemical restraint or an assessment of the patient for this incident.</p> <p>On 7/13/09 at 9:30 PM, a physician's order was received for "Ativan 2 mg by mouth x 1 dose due to patient refused to take the Seroquel 100 mg." The facility failed to produce a DOR for a chemical restraint or an assessment of the patient for this incident.</p> <p>On 7/14/09 at 9:15 AM, a physician's order was received for "Ativan 2 mg IM x 1, Benadryl 50 mg IM x 1 for aggressive behavior, therapeutic restraint x 30 minutes or till patient calms down." The facility did not produce a DOR for a chemical restraint or an assessment of the patient for this</p>	S 602	<p>pertaining to restraints.</p> <p>Develop database to track signed statements.</p> <p>10/15/09</p> <p>Rounding Sheet completed by nurse supervisors has been implemented. This includes direct observation of the use of restraints on each unit (at least 2x per shift @ random times). Nurse supervisors will monitor medical records to ensure physician order is obtain and documented within one hour after the initiation of a restraint. If any violation of the policy or procedures is observed, there will be immediate follow-up of corrective procedures. Rounding Sheet is reviewed daily by DON and CPM II for oversight and compliance.</p> <p>10/08/09</p> <p>Nurse supervisors under the direction of the DON will conduct monthly medical record audits to monitor use of restraints and seclusion, physician orders obtained and documented, length of restraints and seclusion, medications administered and documented, reasons and results of medication documented in MAR, patient/staff injury, denial of rights, debriefing, post intervention assessment, pain assessment, content of patient progress notes, etc. Audit information will be submitted to the Quality Assurance Department for assessment. Data will be presented to monthly LET meetings for quality and program improvement.</p> <p>11/20/09</p> <p>S 332 – Physical Restraint Use</p> <p>DWTC is developing an effective process through quality assurance for reducing the use of restraints via the introduction of preventative strategies and the provision of innovative alternatives. DWTC is developing a plan to reduce the number of physical and chemical restraints.</p> <p>11/20/09</p> <p>The Quality Assurance Specialist will enhance the tracking method of physical and chemical restraints by identifying specific trends and factors precipitating and resulting from restraints. In doing so, the Quality Assurance Specialist will continue to consult with the Medical Director and Director of Nursing (DON) to operationally define</p>	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2128HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/27/2009
NAME OF PROVIDER OR SUPPLIER DESERT WILLOW TREATMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6171 W CHARLESTON BLVD, Bldg. #17 LAS VEGAS, NV 89402 8146		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 602	<p>Continued From page 28</p> <p>incident.</p> <p>On 7/14/09 at 10:00 AM, a physician's order was received for "Ativan 5 mg IM x 1 severe aggression, patient kept in locked seclusion due to severe aggression for safety issue." The facility did not produce a DOR for chemical restraint or an assessment of the patient for this incident.</p> <p>On 7/14/09 at 8:00 PM, a physician's order was received for "Haldol 5 mg IM STAT and Benadryl 50 mg IM STAT for increase anxiety." The 15 minute monitor log (DWTC Form #33) documented 22 oppositional behavior episodes from 7:00 AM to 2:45 PM and 12 episodes of aggressive behavior documented for same time period. The facility did not produce a DOR for a chemical restraint or an assessment of the patient for this incident.</p> <p>On 7/20/09 at 8:00 PM, a physician's order was received for "Haldol 5 mg IM STAT and Benadryl 50 mg IM STAT due to severe anxiety/agitation/threatening to hurt others." The 15 minute monitor log documented 12 physical and verbal abuse, non-compliant behaviors from 7:00 AM to 2:45 PM and 12 episodes of aggressive behavior documented for same time period. The facility did not produce a DOR for chemical restraint or an assessment of the patient for this incident.</p> <p>On 7/21/09 at 2:10 PM, a physicians order was received for "Benadryl 50 mg IM, Haldol 5 mg IM STAT x 1 for severe aggressive behavior towards staff." The 15 minute monitor log documented nine oppositional behavior episodes from 7:00 AM to 2:45 PM and three episodes of aggressive behavior documented for same time period. The facility did not produce a DOR for chemical</p>	S 602	<p>trends and factors related to restraints.</p> <p>The identification of specific trends and factors related to physical and chemical restraints will assist DWTC in developing preventive strategies and innovative alternatives to the use of restraints and also for improving the process of using restraints.</p> <p>The Quality Assurance Specialist will report identified trends and factors resulting from physical and chemical restraints to the monthly LET meeting. LET will utilize data to determine preventive strategies and alternatives to the use of restraints and also for improving the process of using restraints.</p> <p>The Quality Assurance Specialist has begun to improve and build upon the process of tracking patient injuries during Conflict Prevention and Response Training (CPART) holds and seclusions. The method is improving from tracking whether or not an injury had occurred to tracking specific types of injuries (i.e., leg, arm, shoulder, rug burn, etc.).</p> <p>The Quality Assurance Specialist will report the specific types of injuries to the monthly LET meeting. LET will utilize data to determine preventive strategies and to assist in developing a plan for reducing the number of restraints.</p> <p>DWTC is developing a plan to reduce the number of physical and chemical restraints. CPART courses for certification and recertification were reviewed and revised to ensure the protection of all patients.</p> <p>CPART courses include increased practice and role modeling (return demonstration) of all approved CPART holds. Courses also include increased emphasis on preventive techniques and de-escalation content (proactive intervention).</p> <p>Policies, including the Incident/Accident Reporting policy and Restraint/Seclusion of Patients policy,</p>	<p>12/31/09</p> <p>01/29/10</p> <p>11/13/09</p> <p>12/04/09</p> <p>09/30/09</p> <p>10/29/09</p> <p>10/15/09</p>	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2128HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/27/2009
NAME OF PROVIDER OR SUPPLIER DESERT WILLOW TREATMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6171 W CHARLESTON BLVD, Bldg. #17 LAS VEGAS, NV 89102 89146		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 602	<p>Continued From page 29</p> <p>restraint or an assessment of the patient for this incident.</p> <p>On 7/24/09 at 5:46 PM, a physician's order was received for "CPART for patient and staff safety, IM Haldol 5 mg/Benadryl 50 mg IM now." The 15 minute monitor log documented seven oppositional behavior episodes from 3:00 AM to 10:45 PM and four episodes of aggressive behavior documented for same time period. The facility did not produce a DOR for a chemical restraint or an assessment of the patient for this incident.</p> <p>On 7/26/09 at 9:30 PM, a physician's order was received for "Ativan 5 mg IM or PO, CPART for patient and staff safety." The 15 minute monitor log documented two oppositional behavior episodes from 3:00 AM to 10:45 PM and six episodes of aggressive behavior documented for same time period. The facility did not produce a DOR for a chemical restraint.</p> <p>On 7/27/09 at 5:30 PM, a physician's order was received for "Ativan 4 mg IM and Haldol 5 mg IM now agitation." The facility did not produce a DOR for a chemical restraint or an assessment of the patient for this incident.</p> <p>On 7/30/09 at 11:40 PM, a physician's order was received for "Ativan 4 mg IM and Haldol 5 mg IM STAT, agitation." The facility did not produce a DOR for chemical restraint or an assessment of the patient for this incident.</p> <p>On 8/1/09 at 7:10 PM, a physician's order was received for "Ativan 4 mg IM STAT and Haldol 5 mg IM STAT due to aggressive behaviors and increase agitation." The incident report for 8/7/09 at 1:00 PM documented patient to patient</p>	S 602	<p>were revised for heightened clarity and for the protection of all patients.</p> <p>A series of mandatory staff in-services were conducted at DWTC to include retraining on policies, emphasis on preventive and de-escalation techniques, and use of physical and chemical restraints.</p> <p>The Quality Assurance Specialist will be tracking and reporting specific trends and factors pertaining to physical and chemical restraints, including involved patients and staff, type of injuries, type of holds, etc. This data will be utilized to determine preventive strategies, alternatives, and a plan to reduce the number of physical and chemical restraints.</p> <p>The CPM II will monitor and ensure that DWTC has an effective, comprehensive quality improvement program to evaluate the provision of care to its patients, as well as an effective plan to reduce the number of physical and chemical restraints and also to improve the process of using restraints.</p> <p>S 602 – Psychiatric Services</p> <p>DWTC will execute policies and procedures for the provision of psychiatric treatment and behavioral management services to ensure treatment and services protect the safety and rights of all patients (Patients # 5, #6, #7, #8, and #9 remain in inpatient treatment at DWTC). Nurse supervisors will monitor the psychiatric services of all patients, particularly the treatment and medical records of Patients #5 - #9.</p> <p>1. Administration and nurse supervisors enforce policies and procedures to ensure psychiatric treatment and services protect the safety and rights of all patients through clinical meetings, supervision, and shift change.</p> <p>Nursing staff will consistently obtain physician orders for all chemical and physical restraints and</p>	<p>10/29/09</p> <p>01/29/10</p> <p>01/29/10</p> <p>09/11/09</p>	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2128HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/27/2009
NAME OF PROVIDER OR SUPPLIER DESERT WILLOW TREATMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6171 W CHARLESTON BLVD, Bldg. #17 LAS VEGAS, NV-89102 89146		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 602	<p>Continued From page 30</p> <p>physical aggression. The action taken documented Patient #9 was escorted to the quiet room. There was no documented evidence of a DOR being completed or a that debriefing had occurred. There was no documented evidence a complete physical assessment completed after the restraint was implemented. There was no documentation of how the patient was escorted to the quiet room. The facility did not produce a DOR for a chemical restraint or an assessment of the patient for this incident.</p> <p>On 8/7/09 at 4:55 PM, a physician's order was received to "Locked seclusion secondary to homicidal threats, Ativan 2 mg po x 1 acute hostility/posturing." The facility did not produce a DOR for chemical restraint or an assessment of the patient for this incident.</p> <p>On 8/11/09 at 6:00 PM, a physician's order was received for "Thorazine 50 mg IM STAT for increase anxiety and per patient request." The facility did not produce a DOR for a chemical restraint or an assessment of the patient for this incident.</p> <p>On 8/15 at 7:30 PM, a physician's order was received for "Thorazine 50 mg x 1 now." The facility did not produce a DOR for chemical restraint or an assessment of the patient for this incident. There was no documented route for the medication found on the physician's order.</p> <p>Complaint #NV00022688</p> <p>Patient #7</p> <p>Patient #7, a 15 year old male, was admitted on 7/10/09, with the diagnoses that included depressive disorder, history of psychotic disorder,</p>	S 602	<p>seclusions per hospital policy.</p> <p>Nursing staff will consistently document all physician orders in patients' medical records.</p> <p>Nursing staff will consistently document all restraints and seclusions in patients' medical records and through the use of an Incident/Accident Report, Seclusion and Restraint Emergency Procedures Denial of Rights form, Pain Assessment form, and the Restraint and Seclusion Debriefing & Positive Behavior Intervention Plan.</p> <p>Nursing staff will consistently complete a denial of rights form for all instances when patients are placed in physical restraints and seclusion, and when chemical restraints are used.</p> <p>Note: During the September 17, 2009 meeting of the Commission on Mental Health and Developmental Services, this body committed to discuss the Seclusion and Restraint Emergency Procedures form in relation to patient denial of rights at their next meeting scheduled for November 19, 2009. If the intent of the Commission is to continue to utilize the form as a denial of rights, then a request will be made to include "Denial of Rights" in the title of the form. The Commission's authority regarding denial of rights is set forth in NRS 433.534. DWTC will follow the guidance of the Commission and the Attorney General's Office regarding the reporting requirements and the Commission's decisions per their statutory authority.</p> <p>Nursing staff will consistently document all PRN medications, one time medications, and STAT medication orders on the MAR.</p> <p>Nursing staff will consistently document the reasons and results for all IM PRN (intramuscular as needed) medication. The reasons and results will be documented on the back of the MAR and in the patient's medical record.</p>	<p>09/11/09</p> <p>09/11/09</p> <p>09/11/09</p> <p>11/19/09</p> <p>10/29/09</p> <p>10/29/09</p>	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2128HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/27/2009
NAME OF PROVIDER OR SUPPLIER DESERT WILLOW TREATMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6171 W CHARLESTON BLVD, Bldg. #17 LAS VEGAS, NV 89102 89146		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 602	<p>Continued From page 31</p> <p>history of impulse disorder, and history of oppositional defiant disorder.</p> <p>On 7/10/09 at 12:30 PM, a physician's order was received for "Haldol 5 mg IM STAT, Ativan 2 mg IM STAT, Benadryl 50 mg IM STAT for severe anxiety and aggressive behavior." The facility did not produce an Incident/Accident report, assessment, nor DOR for this incident. The IM medications were documented on the MAR as given; nothing was documented on the back of the MAR in the "Reasons and Results" section.</p> <p>On 7/11/09 at 11:27 AM, a physician's order stated "physical restraint up to 2 hours for physical aggression, Haldol 5 mg IM and Benadryl 50 mg IM STAT." The facility did not produce an Incident/Accident report, assessment, nor DOR for this incident.</p> <p>On 7/21/09 at 12:30 PM a physician's order was received for "Haldol 5 mg IM STAT, Ativan 2 mg IM STAT, Benadryl 50 mg IM STAT." The facility did not produce an Incident/Accident report, assessment, nor DOR for this incident. The medications were documented on the MAR as given. However, nothing was documented on the back of the MAR in the "Reasons and Results" section.</p> <p>On 8/9/09 8:05 PM, an incident report documented a "CPART hold, Haldol 5 mg IM, Benadryl 50 mg IM" to be given. The facility did not produce a DOR for this incident.</p> <p>Patient #8</p> <p>Patient #8, a 12 year old male, was admitted on 8/7/09, with a diagnosis of mood disorder.</p>	S 602	<p>All medications will be documented by name, dosage, time, route, and reason.</p> <p>A consent form for all medication will be consistently obtained from parent/legal guardian.</p> <p>Nursing staff will consistently complete and document a physical assessment for each occurrence of restraint and seclusion. This will be documented on the Incident/Accident Report and in the patient's medical record.</p> <p>2. Administrators, supervisors, and peer trainers conduct staff in-service/training to ensure psychiatric treatment and services protect the safety and rights of all patients.</p> <p>Retrain staff on Incident/Accident Reporting policy.</p> <p>Retrain staff on Restraint/Seclusion of Patients policy.</p> <p>Retrain staff on NAC 449.3628 – Protection of Patients.</p> <p>Retrain staff on NRS Patient Rights 449.700 – 449.730.</p> <p>3. Monitor compliance that psychiatric treatment and services protect the safety and rights of all patients.</p> <p>Mandate review of all policies pertaining to restraints and seclusion.</p> <p>Create and institute signed Statement of Understanding of having read, understood, and will adhere to all policies and procedures pertaining to restraints and seclusion.</p> <p>Develop database to track signed statements.</p>	<p>10/29/09</p> <p>10/29/09</p> <p>10/29/09</p> <p>10/29/09</p> <p>10/29/09</p> <p>10/29/09</p> <p>10/29/09</p> <p>10/29/09</p> <p>10/29/09</p> <p>10/15/09</p>	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2128HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/27/2009
NAME OF PROVIDER OR SUPPLIER DESERT WILLOW TREATMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6171 W CHARLESTON BLVD, Bldg. #17 LAS VEGAS, NV 89102 89146		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 602	<p>Continued From page 32</p> <p>A registered nurse progress note dated 8/11/09, read "Escorted to hallway down to quiet room and was making negative remarks to staff in an intimidating fashion. Given Benadryl IM at 9:15 AM which he initially refused but with firm redirection cooperated with procedure." The facility did not produce an Incident/Accident report, Assessment, nor DOR for this incident.</p> <p>A physician's order dated 8/11/09 at 9:14 AM read "Benadryl 25 mg IM STAT for severe anxiety." The MAR provided indicated the Benadryl was given, however there was no "Reason and Results" recorded for the medication.</p> <p>An RN progress note written on 8/13/09 read "He refused to go to Quiet Room, then he postured to hit staff with a closed fist. CPART hold was implemented. Dr. was made aware of the incident. Benadryl 25 mg IM was ordered and was given at 4:50 PM." A physician's order dated 8/13/09 at 4:45 PM read "CPART ..., Benadryl 25 mg IM Now." The MAR indicated the Benadryl was given, there was no "Reason and Results" recorded for the medication. There was no "Denial of Rights" completed for the Benadryl IM. The record did not contain a consent form for the use of the Benadryl.</p> <p>Patient #5</p> <p>Patient #5, a 16 year old female, had a current admit date on 6/24/09 and a previous admission on 5/7/09. Her diagnoses included bipolar disorder, mixed, severe psychosis, eating disorder, and post traumatic stress disorder.</p> <p>Patient #5 was prescribed and given Benadryl 50 mg by mouth as needed for anxiety on 7/6/09 at</p>	S 602	<p>Rounding Sheet completed by nurse supervisors has been implemented. This includes direct observation of the use of restraints and seclusion on each unit (at least 2x per shift @ random times). If any violation of the policies or procedures is observed, there will be immediate follow-up of corrective procedures. Rounding Sheet is reviewed daily by DON and CPM II for oversight and compliance.</p> <p>Nurse supervisors receive from unit charge nurses completed Incident/Accident Report, Seclusion and Restraint Emergency Procedures Denial of Rights form, Pain Assessment form, and the Restraint and Seclusion Debriefing & Positive Behavior Intervention Plan for each restraint and seclusion by the end of shift incident occurred. Forms are reviewed for accuracy and completeness. If any error is detected, there will be immediate follow-up of corrective action. Forms are submitted daily to DON for review and oversight.</p> <p>Nurse supervisors under the direction of the DON will conduct monthly medical record audits to monitor use of restraints and seclusion, physician orders obtained and documented, length of restraints and seclusion, medications administered and documented, reasons and results of medication documented in MAR, patient/staff injury, denial of rights, debriefing, post intervention assessment, pain assessment, content of patient progress notes, etc. Audit information will be submitted to the Quality Assurance Department for assessment. Data will be presented to monthly LET meetings for quality and program improvement.</p> <p>The Quality Assurance Specialist will compare patient progress notes with database that contains all submitted Incident/Accident Reports and Restraints/Seclusions for accurately capturing and appropriately documenting all incidents. Twenty patient cases will be randomly selected per quarter. Discrepancies will be brought to the attention of the CPM II within one business day for further investigation and corrective action if necessary.</p>	<p>10/08/09</p> <p>09/29/09</p> <p>11/20/09</p> <p>09/16/09</p>

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2128HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/27/2009
NAME OF PROVIDER OR SUPPLIER DESERT WILLOW TREATMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6171 W CHARLESTON BLVD, Bldg. #17 LAS VEGAS, NV 89102 89116		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
S 602	<p>Continued From page 33</p> <p>5:00 PM; 7/12/09 at 4:30 PM; 7/13/09 at 8:00 PM; 7/14/09 at 8:00 PM; 7/26/09 at 5:30 PM; and 7/30/09 at 4:45 PM. The "Reasons and Results" for the medications were not documented on the back of the MAR.</p> <p>On 5/10/09 at 4:55 PM an incident was documented that "staff held her from 3:55 to 4:55." The description of occurrence section of the report read "at start of shift IM meds to include Ativan, Benadryl and Zyprexa after refused to take PO. Needed PRN meds as she was hitting, kicking ..."</p> <p>On the physician order for 5/10/09, the RN documented "5/10/09 11:45 PM error noted 5/10/09 3:50 PM Benadryl 50 mg and Ativan 1 mg IM STAT." The MAR indicated the Benadryl and Ativan were given at 3:40 PM. No "Reasons and Results" were recorded on the back of the MAR.</p> <p>The July 2009 MAR indicated Benadryl 50 mg PO (orally) PRN was given on six occasions. The "Reason and Results" section of the MAR provided was blank.</p> <p>Patient #6</p> <p>Patient #6, a 15 year old male, was admitted on 2/2/09, with the diagnosis of psychotic disorder.</p> <p>On 7/3/09 at 9:00 PM an incident was recorded as "CPART hold and Benadryl 50 mg IM STAT. A physician's order on 7/3/09 at 9:00 PM read"..., Benadryl 50 mg IM STAT." The MAR did not indicate the Benadryl 50 mg IM STAT was given on 7/3/09 at 9:00 PM.</p> <p>On 7/11/09 at 10:15 AM a physician's order was</p>	S 602			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2128HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/27/2009
NAME OF PROVIDER OR SUPPLIER DESERT WILLOW TREATMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6171 W CHARLESTON BLVD Bldg. #17 LAS VEGAS, NV 89102 89146		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 602	<p>Continued From page 34</p> <p>written for "Benadryl 50 mg IM STAT, Haldol 5 mg IM STAT for severe anxiety and physical aggression." The facility did not produce an Incident/Accident report, assessment, nor DOR for this incident. The MAR provided indicated the medications were given. There were no "Reasons and Results" documented on the MAR for the medications.</p> <p>On 7/13/09 at 8:30 PM, an incident was recorded as a "... Benadryl 50 mg, Ativan 2 mg, Haldol 5 mg IM given." There was no physician's order for the Benadryl 50 mg, Ativan 2 mg, or Haldol 5 mg IM. The MAR provided indicated Benadryl 50 mg, Ativan 2 mg, and Haldol 5 mg IM were given at 8:00 PM.</p> <p>On 7/18/09 at 11:55 AM, a physician's order read "CPART hold for physical/violent aggression. Benadryl 50 mg IM STAT, Ativan 2 mg IM STAT, and Haldol 5 mg IM STAT. The Benadryl, Ativan, and Haldol were not on the MAR provided.</p> <p>Interviews with the Director of Nursing (DON) revealed when a IM PRN medication was given the nurses (RN) were to record the "Reasons and Results" on the back of the MAR.</p> <p>An interview on 8/25/09 at 2:45 PM with a unit RN revealed the nurses did not always document the "reasons and results" of PRN medication on the MAR.</p> <p>An interview on 8/26/09 at 10:30 AM with another RN revealed he would complete the "reasons and results" on the MAR if the medication was an antipsychotic or an intramuscular administration.</p> <p>Severity: 3 Scope: 3</p>	S 602			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.